DOCUMENT RESUME

ED 037 748 CG 005 054

AUTHOR	Herschleman, Philip; Freundlich, David
TITLE	Group Therapy with Multiple Therapists in A Large Group.
INSTITUTION	Philadelphia Naval Hospital, Pa.
PUB DATE	May 69
NOTE	12p.
AVAILABLE FROM	Dr. Philip Herschleman, Philadelphia Naval Hospital, 17th Street and Pattison Avenue, Philadelphia, Pennsylvania 19145
EDRS PRICE	EDRS Price MF-$0.25 HC-$0.70
DESCRIPTORS	*Group Therapy, *Institutional Environment, Program Descriptions, Psychiatric Hospitals, *Psychological Services, *Psychologists, Psychotherapy, Techniques, Therapeutic Environment, *Therapists

ABSTRACT

The utilization of multiple therapists in large group therapy meetings has been found to be a significant improvement over the traditional ward meeting or patient-staff conference. The initially limited goals of reducing ward tension and acting out by means of patients ventilation were surpassed. Despite the size of the meetings it was often possible to meaningfully explore affect-laden areas. The after-group meetings contributed appreciably to the therapists' professional growth and to the general morale of the therapeutic team. The multiple therapist technique could provide an additional and effective treatment modality in many institutional settings characterized by a large patient-therapist ratio, and where treatment is usually restricted to chemotherapy and ward milieu. (KJ)

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

ED037748

GROUP THERAPY WITH MULTIPLE THERAPISTS IN A LARGE GROUP

Philip Herschleman, M.D. and David Freundlich, M.D.

The authors are currently serving as Staff Psychiatrists at the Philadelphia Naval Hospital. Other participants in this project were Drs. P. Milstein, D. Grayson, R. Bridburg, A. Schubert, R. Niccolini, S. Sibert, J. Donnelly, N. Howard, R. Stice, and K. Gaines.

May 1969.

Opinions expressed herein are those of the authors and do not necessarily reflect the views of the Navy Department or of the Naval Service at large.

CG005054

GROUP THERAPY WITH MULTIPLE THERAPISTS IN A LARGE GROUP

Philip Herschelman, M.D. and David Freundlich, M.D.

Most group therapists concur that potential therapeutic success is greatest in small groups of approximately eight to ten patients. Likewise, most therapists agree that attempting to treat a large group of 35 to 45 patients is not only frustrating but of questionable therapeutic value. With the increasing popularity of ward or unit group therapy meetings, many a therapist has faced a large group of hospitalized patients and in the process has felt overwhelmed by massive patient resistance and hostility. More often than not he departs from this experience vowing, "Never again!" However, it is interesting to note how infrequently multiple therapists are utilized in such large groups. Many explanations can be given for this. For example, it could be assumed that too many doctors spoil the group. More precisely, diverse interpretations of group phenomena would result in confusion rather than clarification. Or, the varying personalities, backgrounds and needs of the the multiple therapists would conflict and stimulate rivalry and staff dissension, rather than therapeutic cooperation.

An attitude of skepticism permeated a group of psychiatrists working on the in-patient psychiatric service of the Philadelphia Naval Hospital when the unit head proposed that ward group therapy meetings be held which would be attended by the entire patient population and staff. The staff members remained pessimistic about the venture despite an agreement that only relatively limited goals would be pursued in the group; namely, reduction of ward tension by means of patient ventilation. It was hypothesized that a diminution of ward tension would make the patients' hospital stay more palatable as well as decrease patient acting out.

The group meetings were of one hour duration and were held on the open and closed wards on a weekly basis. The meetings usually involved 35 to 45 patients,

five staff psychiatrists, two or three psychiatric residents, two hospital corpsmen, and one psychiatric nurse. This was reducible to a ratio of one therapist to every four patients. Since it was impossible to seat everyone in a large circle, the chairs were arranged in loosely concentric ovals. The patient population was about evenly divided between the diagnostic categories of schizophrenia and personality disorders. The patient turn-over was rapid with about twelve new patients arriving weekly. The usual length of hospitalization was from four to twelve weeks. Most of the patients were poorly motivated for therapy; their main interest was their future military disposition, that is, whether or not they would be discharged from the Navy or Marine Corps.

Early Group Meetings and the After-Group Group

In the initial group meetings there was considerable acting out on the part of the therapists. For example, whereas the patients were generally punctual, the therapists were frequently five to ten minutes tardy. Another defensive ploy utilized by the therapists was passivity and non-participation in the meetings, this tactic being made easier because of the aggressive participation by the unit head. However, as the therapists became more involved in the meetings, their initial resistance and skepticism gradually gave way to active participation and enthusiasm. Consequently, after-group meetings spontaneously evolved which were held immediately following the large group meetings. On the open ward the after-group sessions were held in the presence of the patients, utilizing the staff-patient conference techniques proposed by Berne (1).

The after-group groups were indispensable because they provided a forum where open communication between the therapists could be established. They

proved especially helpful in resolving rivalry, anger, and various disagreements among the therapists. For example, one therapist irritated the others by his questioning of individual patients, much in the same manner as would be done in individual psychotherapy sessions. This technique frequently diverted the group from group affect and often resulted in a boring, intellectual dialogue between patient and therapist. When confronted about this technique in the after-group sessions, the therapist was able to reconsider his previously learned individual therapy techniques in favor of an approach which encouraged the expression of group affect and dealt with resistance in the group as a whole. All the therapists, to a greater or lesser degree, went through similar modifying experiences under the critical but supportive eyes of their colleagues. Although at times it was indeed painful to discover one's own flaws and weaknesses as a group therapist, nevertheless, an atmosphere of frankness and honest appraisal was maintained.

The after-group meetings were also helpful in exploring the change in attitudes of the therapists from initial resistance to active participation. All agreed that their initial resistance to participate in the meetings was merely a camouflage for their own fears. For example, most of the therapists openly acknowledged their concerns as to how they would appear as therapists in the eyes of their colleagues. The after-group groups, therefore, were an important learning experience for the therapists in that group therapy technique, countertransference, and therapist interaction could be discussed.

The Technique, Advantages, and Problems of Multiple Therapists

In the large group meetings it soon became evident that an even dispersal of therapists about the room contributed to a secure feeling among both the

patients and staff, and made it easier to deal with destructive forces in the meeting. The need for this became glaringly apparent when it was observed that some patients frequently arrived early in order to manipulate the seating. For example, there were meetings in which patients diagnosed as character disorders sat together in one section of the room. As the meeting progressed this seating arrangement proved to be extremely disruptive. Despite the presence of many therapists, this cluster of resistive patients became impenetrable and resulted in decreased group interaction. This problem was solved quite simply by one or two therapists merely approaching such a group at the beginning of the meeting and requesting that particular patients exchange seats with them. When the therapists were evenly dispersed throughout the group, each was able to keep an eye on the small group of patients seated in his immediate vicinity. The acting out of a character disorder, or the bizarre behavior and verbalizations of a psychotic patient could thus be handled by having those patients sit next to a staff member. For example, if a patient attempted to carry on a private conversation with his neighbor, a therapist in that vicinity would invite those patients to share their thoughts with the entire group. Sometimes when the meetings became charged with feeling, those patients who were not participating found it difficult to continue in silence. No longer able to vent to their neighbor,they often became active participants in the meeting.

Another lesson learned early in the large group experience was that the therapists were much more effective if they behaved as "real" people who expressed their own feelings. Many of the therapists were apprehensive about assuming this role since they had been accustomed to being more detached observers during psychotherapy sessions. This type of withholding approach in the

large group meetings usually resulted in similar behavior by the patients. On the other hand, when the staff more freely shared feelings and reactions with the patients, the latter felt more confident about doing the same. This atmosphere was also conducive to helping the patients become aware of how they came across to others. In addition, patient identification with the therapists was enhanced when the therapists allowed themselves to be real "living" persons in the group meetings. Therapist-therapist interactions, therapist-patient exchanges, and the variety of therapeutic personalities present resulted in an expanded base available for patient identification. At the same time the functioning of the therapists as real persons was of benefit in destroying the patients' myth (and frequently the staffs') that the therapists were omnipotent and omniscient beings.

One of the striking advantages of multiple therapists was the enhanced ability to confront and quickly deal with patient resistance so as to readily reach significant, affect-laden material. In the group meetings the patients were simply not allowed to dwell on resistive topics such as hospital regulations, society, the world political scene, etc. The therapists in an assertive fashion redirected the discussion to the here-and-now of the ward setting and the group. For example, one therapist might say, "Okay, that's the situation in Vietnam, but what's happening in this room?" Or, if appropriate to the particular meeting, another therapist might interject, "Are we at war in this room?" Despite utilizing an aggressive therapeutic approach, instances of patients losing control or of extreme impulsive behavior were unusual. Even on those occasions when anxiety became intense and a patient would begin to leave the room (on the pretext of having to go to the bathroom), it was usually possible for the therapists to

persuade him to remain in the room in order to discuss his resistance to the group situation.

With multiple therapists present, it was quite natural for therapists to follow-up and reinforce a meaningful interpretation made by a colleague, that would otherwise be lost in a sea of resistance. For example, when a particular group meeting would become intellectual and vapid, therapist A might comment to the group, "I'm feeling bored - what's happening?" Some patients, fending against significant underlying affect, might collectively disagree that the meeting is dull. At this point other therapists, who were experiencing the same boredom, might reinforce therapist A's interpretation of the tone of the meeting. Frequently, this resulted in subsequent patient corroboration and exploration of the resistance. More often than not there followed an unfolding of intense affect that had been disguised by the aforementioned resistance. In a similar situation a lone therapist would likely find it extremely difficult, if not impossible, to meet and break through such strong resistance.

Another asset of multiple therapists was that different therapists manifested varying sensitivity to the wide spectrum of group phenomena. Therapist B, for example, would pick up a significant covert group affect that therapist A had missed altogether. Or therapist C would point out group interaction at a more superficial level, whereas therapist D would detect group affect at a deeper level. When such situations arose and as the therapists themselves became more comfortable with each other, it became possible for one therapist to lead another away from less productive to more productive areas. On occasion it was deemed appropriate for one therapist to flatly disagree with another. In such a situation it was not at all infrequent for the therapists to become angry with

one another; however, with open communication being encouraged by all, the angry feelings were invariably resolved either during the large group meetings or in the after-group sessions.

Although all the therapists were considered to be of equal stature in the meetings, some therapists invariably felt more comfortable, and thereby functioned more therapeutically, in certain group situations. Some were more capable of handling anger or depression, or at uncovering resistances. Other therapists were more adept at being supportive and reassuring to patients when the group situation indicated that approach.

A vivid example of how a particular therapist handled a situation in more therapeutic fashion than his colleagues is illustrated as follows. In one group meeting, just before the Christmas holidays, the predominant feeling was that of gloom and despair. A heavy, steamy atmosphere permeated the room. It was all too easy to sink down in one's chair and say nothing. The meeting went slowly with little said and many silences. No one focused on the predominant affect of despair. Finally, after approximately forty minutes, one patient became extremely angry and blurted out at the therapists, "You're no doctors!" He accused the staff of making extra money for each additional patient that could be kept in the hospital over the holidays. Most of the therapists responded angrily and met this attack with verbal counterattacks. However, one therapist was able to sidestep the accusations and point out that the patient was upset because he and the other closed ward patients would not be spending the holidays at home with their families. The therapist added that one way of handling despair and depression in such a situation was to become angry, especially with those held responsible for their retention in the hospital. The patient in

turn nodded agreement and ventilated his despair about being confined in the hospital. Other patients then did the same and there resulted a significant dissipation of group tension and partial resolution of the despair.

In addition to the many advantages of the multiple therapist technique, numerous problems also became evident. On occasion the therapists, especially when anxious, talked too much, thereby inhibiting spontaneous interaction by the patients. When frustrated in their therapeutic attempts, the staff sometimes banded together "against" the patients, consequently reinforcing patient resistance. At times, some therapists dominated their colleagues, and, conversely, some therapists found it all too comfortable to be passive and to relinquish active participation to others. The physicians were generally more active than the corpsmen, the latter often feeling insecure, inferior, inadequately trained, and, therefore, less capable of therapeutic contributions. Frequently, the staff prematurely assumed the full responsibility of setting limits on acting out behavior during the meetings, instead of sharing this responsibility with the patients. Since the patients were living together on the ward it would have been more important for them to learn how to confront and deal with each other's disruptive behavior, rather than unnecessarily depending on the staff to do this. It should be mentioned that most of these contertransference and inter-therapist problems were transitory, and were usually successfully resolved in either the large or after-group meetings.

Discussion and Results

The impact of the large group therapy meetings with multiple therapists

exceeded the initial expectations. There was appreciable evidence that the meetings resulted in greater benefits than simply reducing ward tension and patient acting out, and making the ward a more pleasant temporary home. The group, as a whole, learned that certain emotionally laden areas could be explored without courting disaster. Some of the topics that were at first defended against, but later uncovered and discussed in the group were as follows: loss of self-esteem from being a mental patient in a "nut house"; feelings of helplessness and hopelessness usually related to the patients' confinement to the closed ward; fear of becoming "crazy" or living with others who "act crazy"; anxiety concerning death, self-destructive impulses, and suicidal attempts; and apprehension about losing control of impulses. For example, the patients with character disorders frequently were hostile towards and avoided the most psychotic patients. There was evidence that the character disorder patients fantasied that too close contact with psychotic patients would result in uncovering their own imagined psychoses. When this phenomenon was acknowledged and dealt with in the group, there was a noticeable breakdown of barriers between the character disorders and psychotic patients. The psychotic patients in turn, as would be expected, were especially sensitive to and upset by group phenomenon related to loss of control. It was frequently observed that when a particularly impulsive patient was confronted in the group, several psychotic patients invariably disrupted the meeting with fragmented verbiage. Through the collaboration of the multiple therapists the focus would be redirected to the threatening area which would then be discussed. One area generally avoided by the group but clearly part of some meetings was anxiety related to homosexuality.

Although it was impossible to determine whether intra-psychic changes occurred, it was obvious that many patients developed a better understanding as to how they came across to and affected others. For example, patients who often complained of being "picked on" and "harassed" began to see how their own provocative behavior often stimulated retaliatory responses. Thus, a good number of patients were able to modify their behavior and thereby elicit more friendly and receptive attitudes from others.

Of course, not all patients were helped in the group meetings. Certain hard core character disorders strongly resisted all attempts to get them involved in the group. Another patient type that undoubtedly derived minimal benefit was the extremely withdrawn psychotic patient who rejected all invitations to interact in the meetings.

The large group meetings were not only therapeutic for many patients, but also proved to be most helpful to the therapists in their work on the ward. Despite transient jealousy and hostility encountered among the therapists, the predominant attitude and feeling throughout the multiple therapist experience was that of the cohesiveness, group identity, and a spirit of working together. The increased communication among the multiple therapists during the group and after-group meetings led to a striking improvement in staff morale. Furthermore, during the meetings the entire therapeutic team was able to sense the ward atmosphere, to become acquainted with the patients assigned to the various therapists, and to develop sensitivity to potential ward problems.

SUMMARY

The utilization of multiple therapists in large group therapy meetings was

found to be a significant improvement over the traditional ward meeting or patient-staff conference. The initially limited goals of reducing ward tension and acting out by means of patient ventilation were surpassed. Despite the size of the meetings it was often possible to meaningfully explore affect-laden areas. The after-group meetings contributed appreciably to the therapists' professional growth and to the general morale of the therapeutic team. The multiple therapist technique could provide an additional and effective treatment modality in many institutional settings characterized by a large patient-therapist ratio, and where treatment is usually restricted to chemotherapy and ward milieu.

REFERENCE

1. Berne, E. Staff-patient staff conference. Amer. J. Psychiat., 125:3, 42, Sept. 1968.

Authors' Address:

Philadelphia Naval Hospital

17th Street and Pattison Avenue

Philadelphia, Pa. 19145